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COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
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November 22, 2005

TO: Each Supervisor

David Janssen
Chief Administrative Officer

FROM: Thomas L. Garthwaite, MD
Director and Chief Medical Officer

SUBJECT: SEPARATION OF PUBLIC AND PERSONAL HEALTH SERVICES

As your Board moves closer to the consideration of creating a separate Department of Public Health, I have been asked my opinion on the division by several interested parties. I want to make sure that your Board is aware of what I have said and to lay out concerns I have about the proposed separation of these services from the Department of Health Services (DHS).

Health Authority

I have consistently stated that the only compelling reason that I see to separate the two elements of the Department is to allow the creation of an alternative governance structure the personal health portion of DHS. I am not alone in the belief that such a structure is critical to the success of the public healthcare in Los Angeles. It has been supported by the Margolin led task force (1995), the Blue Ribbon Task Force (2002), the USC study (2003), the majority of experts polled by the LA Times, and the LA County Civil Grand Jury (2005). Currently, alternative governance is also supported by the Los Angeles County Medical Association, the Hospital Association of Southern California and the Los Angeles Chamber of Commerce.

Structural competition

Certainly the issues that have arisen over the years between the Departments of Health Services and Mental Health about models of mental health care are due in part to the fact that each department plays a major role in the delivery of these services, yet the planning and budgeting for this care is done independently by each department. In this area, like public health, there is a significant amount of overlap, both clinically and by need, and the fact that physical and mental health services are managed by different departments has led to gaps in care to our patients, despite efforts to the contrary. While the Departments have

been working collaboratively, this is based on the will of the current leadership and is not assured or promoted by the structure. In fact, the competition for county dollars and the ability to independently pitch Board offices works against collaboration. I am concerned that similar problems might arise out of the creation of a separate department for public health.

Structural Collaboration

In 1970, the Board-established Health Services Planning Committee recommended the creation of a single Department of Health Services, that included medical, mental, and public health services. The Planning Committee argued that having multiple departments resulted in fragmentation in the provision of personal health services, duplication of effort, and difficulties in the coordination of many health programs. The Planning Committee also argued that ending the fragmentation, duplication, and coordination problems would allow for the improvement in delivery of services within limited resources. Certainly today, the funds available to support the health care mission are severely limited, probably to an even greater degree than in 1972.

The Board of Supervisors accepted the recommendation of the Planning Committee and approved the creation of a single Department of Health Services that incorporated personal, public, and mental health services. The same arguments that were made for the integration of these services at that time still stand, and may be even more critical, particularly given the increased threat of disease outbreaks such as the avian flu virus and the new threat of bioterrorism. The planning efforts around meeting the needs should such an outbreak occur, point to the critical need for the union of health care functions.

Further, I also believe that the gain from separation of health and human service efforts (current and proposed) must be considered in the context of the real needs in the communities we serve and the achievement of optimal efficiency and coordination in the delivery of services. The greatest unmet healthcare and social burden is in the same geographic areas (Attachments I-XIII) and, in my opinion, the greatest chance to impact those needs is through integration of programs and services not further segregation and silo creation.

The attached maps of Los Angeles County show the tremendous overlap in the population served by DHS personal health facilities and those areas with the greatest public health service needs. In addition, these communities experience significant rates of poverty, uninsurance, unemployment, and violent crime. The amount of overlap in the mission and patient population is significant and thus requires greater integration, not separation.

Communication and Advocacy

Another issue to consider pertains to policy advocacy and public communications on health care delivery system and public health matters. In the advocacy area, while there are many debates that are specific to each field, there are others that have overlapping impact. In addition to efforts to secure necessary funding for planning efforts related to bioterrorism and the potential avian flu pandemic, there are issues associated with expansion of health

coverage to specific populations, changes to enrollment procedures for public health coverage programs, and the use of shared electronic medical records across provider groups. There is a risk of a less effective message if these two functions are not carefully coordinated. Further, there is a risk of mixed communications to the public with two separate departments, particularly in critical areas such as bioterrorism preparedness and management of disease outbreaks. Because the roles of personal and public health are so inextricably linked, so too should be the message.

Allocation of Resources

Finally, the process by which resources are to be redistributed between the two proposed departments is of concern. While the majority of the allocation exercise looked at how resources should be allocated programmatically, it did not take into account already limited administrative infrastructure that presently maximizes resources to meet the needs of both personal and public health. In order to replace many of the administrative functions presently undertaken by the Department, such as human resources, contract monitoring, and other areas, funds will have to be shifted from public health programs or direct patient care to support these needs.

Separate Administrative and Support Functions

It has been argued that an advantage of the separation is that Public Health would not have to compete with other Departmental areas for contracting, personnel and other support services. While that is true, the fundamental weaknesses in these support services are related to the current governance and administrative structures of the County. I see no reason to believe that a separate Public Health Department would be more successful in overcoming these structural weaknesses than DHS has been.

Competition of Funding

I fully understand and accept that there are benefits to the creation of a Department of Public Health in terms of public awareness of their health activities and mission. It is also true that there is a difference in the targeted population between public health (all County residents and visitors) and the remainder of health services (the uninsured and underserved). While there has been no erosion of public health support since I have been Director of DHS, Public Health is right in their concern that there must not be a competition for funding internally between the two functions; rather, difficult prioritization among multiple public needs must be at your Board's discretion.

Alternatives

What surprises me the most about your Board's consideration of this new structure is that all the focus has been on what it would take to effect a separation. To my knowledge, there has been minimal discussion regarding what an improved structure hopes to accomplish and what alternative structures might be considered.

I favor structural change. Your health and human resource Departments are laboring against tremendous need in the areas of health, public health, mental health, poverty, homelessness, and child welfare. In the face of these challenges, I believe that you should consider bolder and more comprehensive steps than simply separating the two entities.

I appreciate the opportunity to present my concerns on this matter. Please let me know if you have any questions.

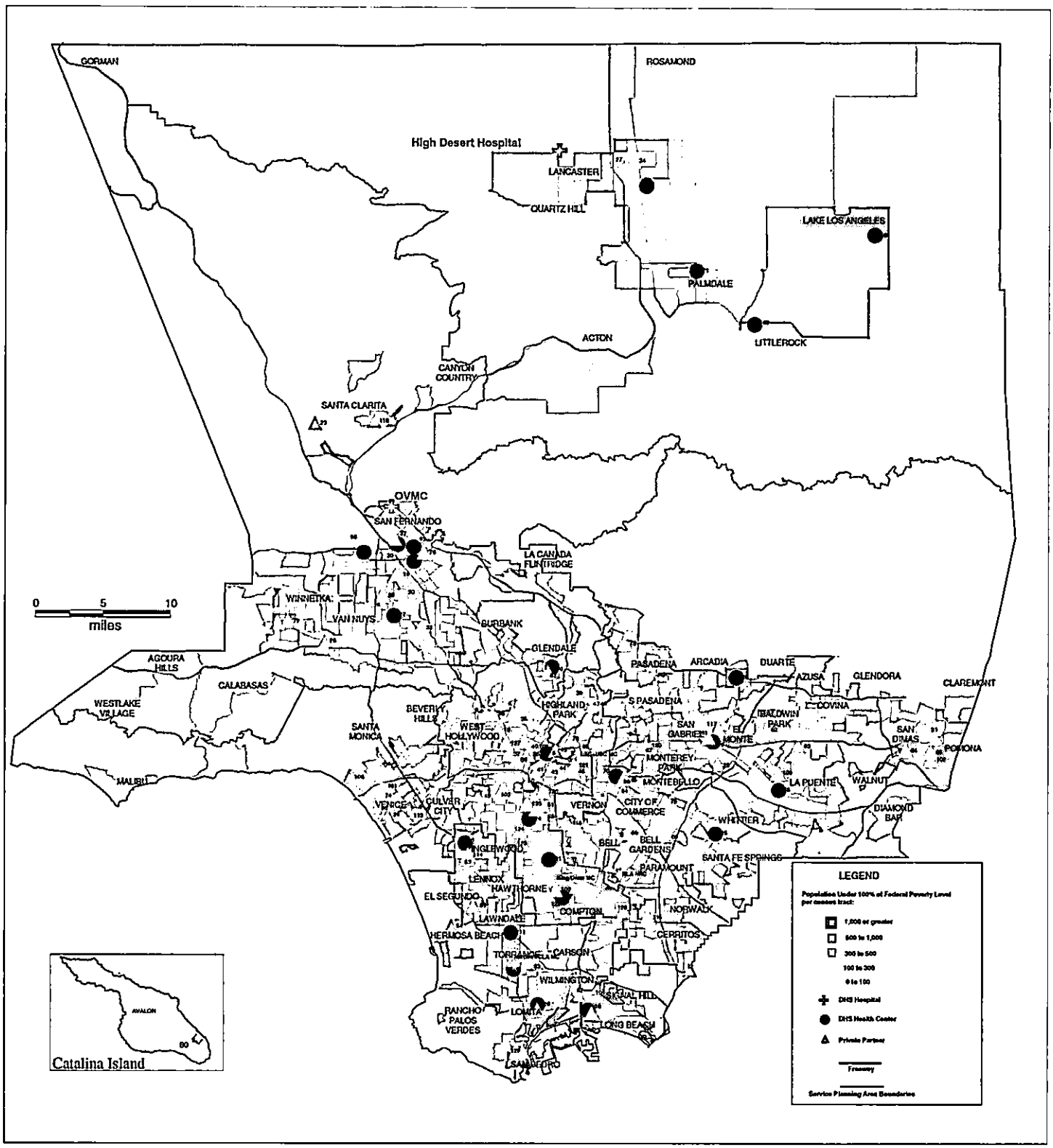
TLG:mds

Attachments

c: Jonathan Fielding, MD

LOS ANGELES COUNTY

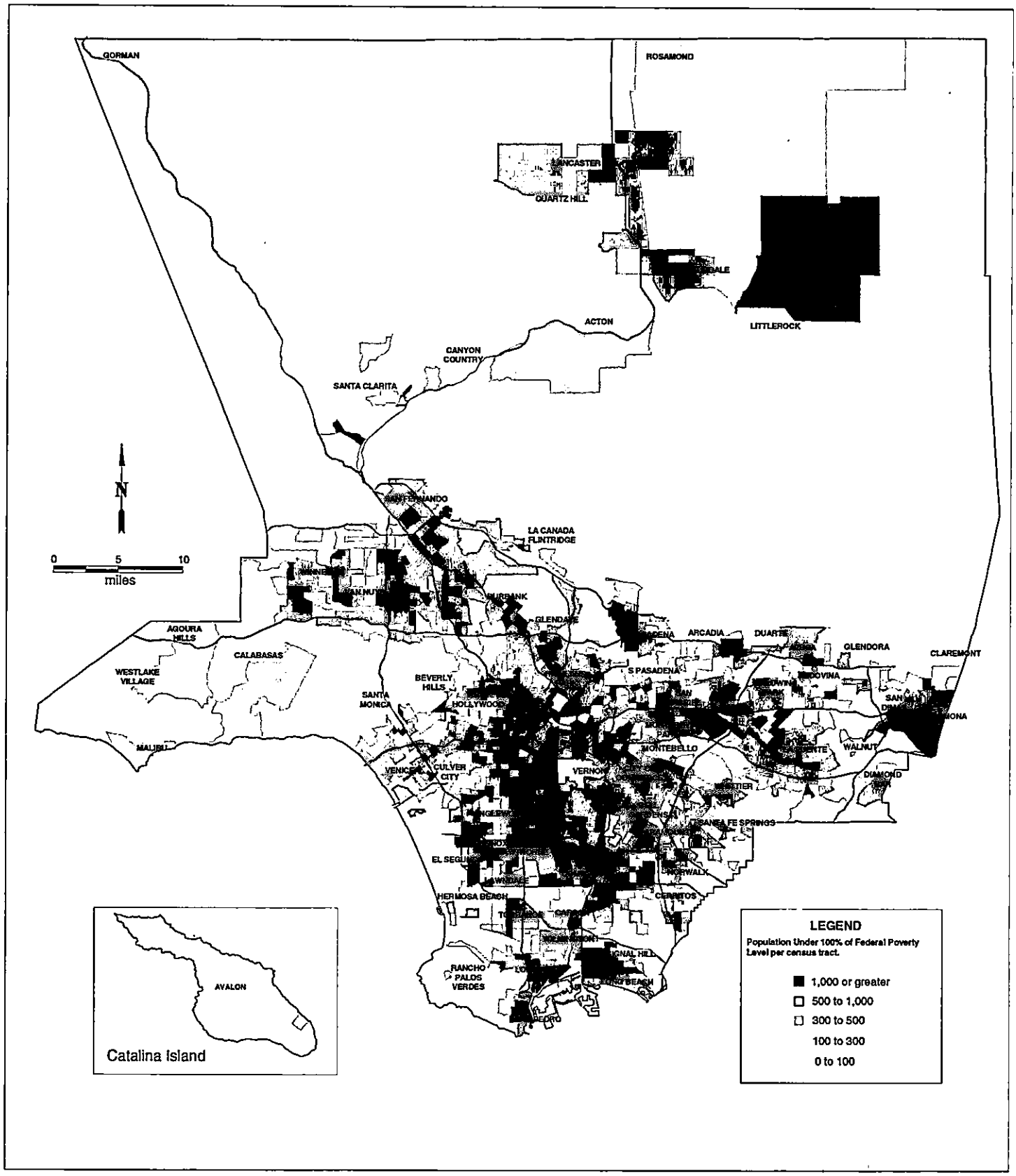
Population Below Federal Poverty Level
DHS and Private Partner Facilities



Source: U.S. Census Bureau, Census 2000, SF3

LAC DHS Office of Planning
June 18, 2003

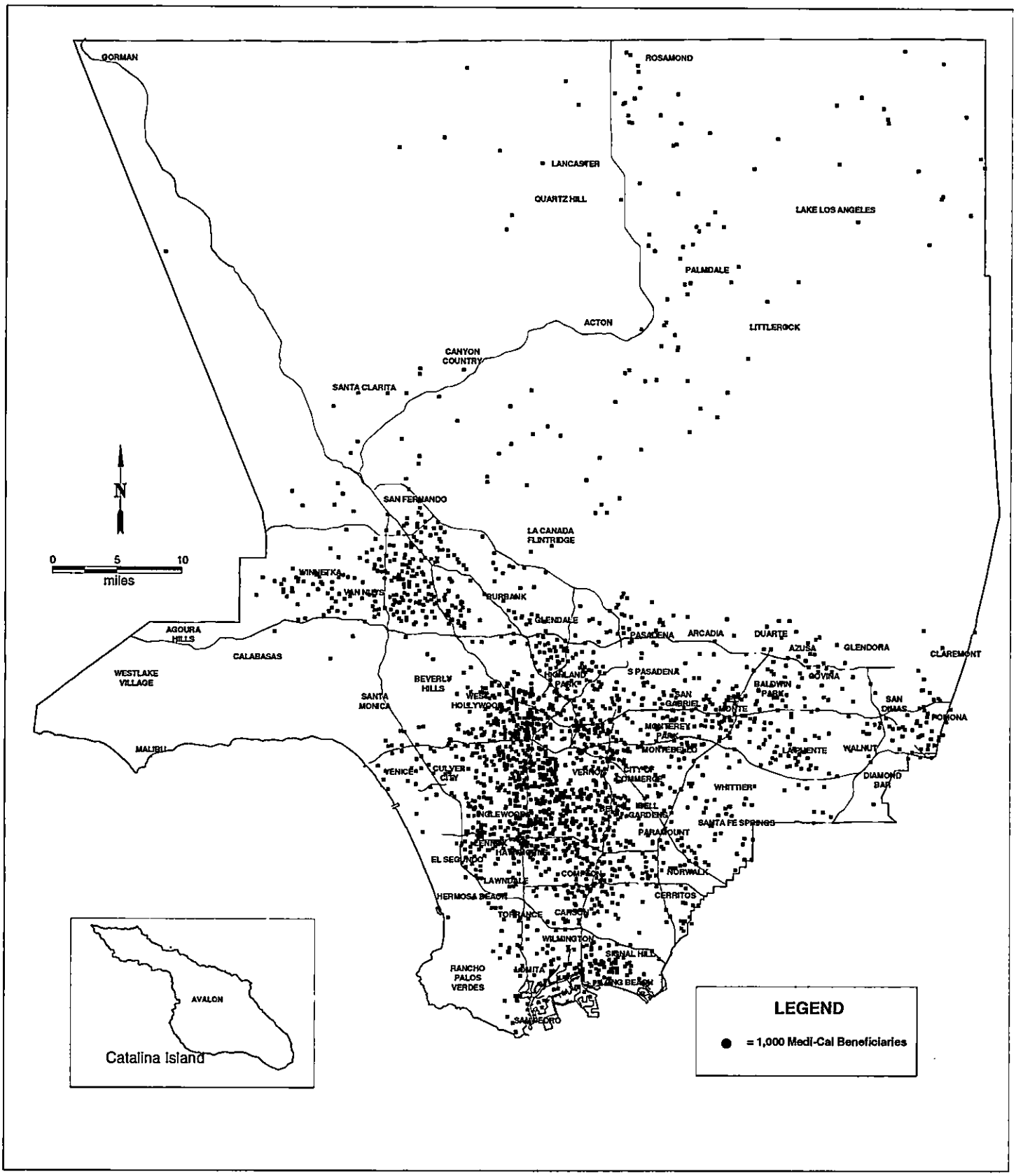
Los Angeles County Population Poverty 100% FPL



Source: U.S. Census Bureau, Census 2000, SF3

LAC DHS Office of Planning, Data Quality and Analysis
November 10, 2005

Los Angeles County
Medi-Cal Beneficiaries by Zip Code



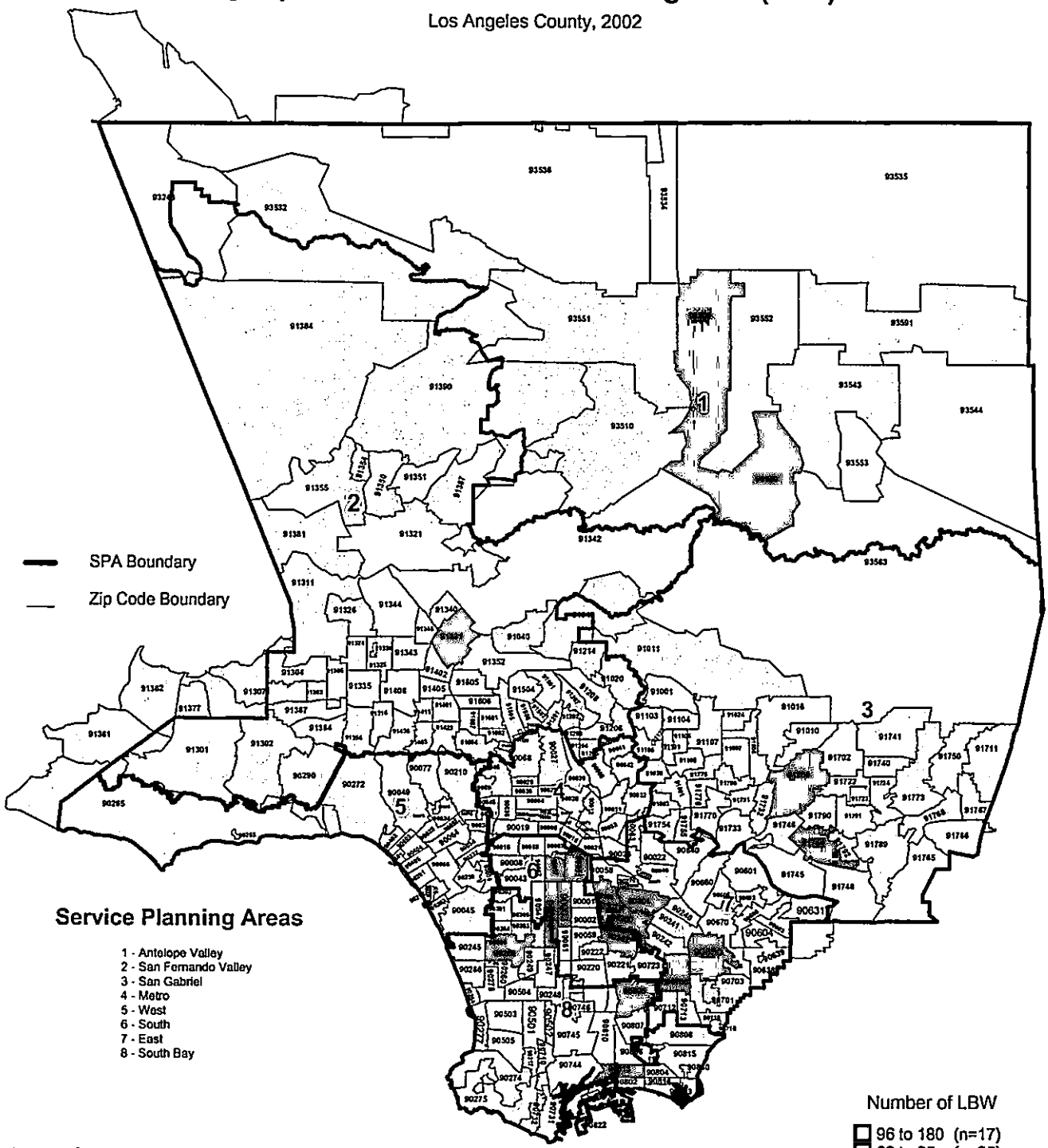
Source: California Department of Health Services, Medical Care Statistics Section, July 2003

LAC DHS Office of Planning, Data Quality and Analysis
November 10, 2005

Los Angeles County - Department of Health Services

Number of Low Birthweight (LBW) Live Births by Zip Code* and Service Planning Area (SPA)

Los Angeles County, 2002



* Los Angeles County zip code boundaries as of April 2002

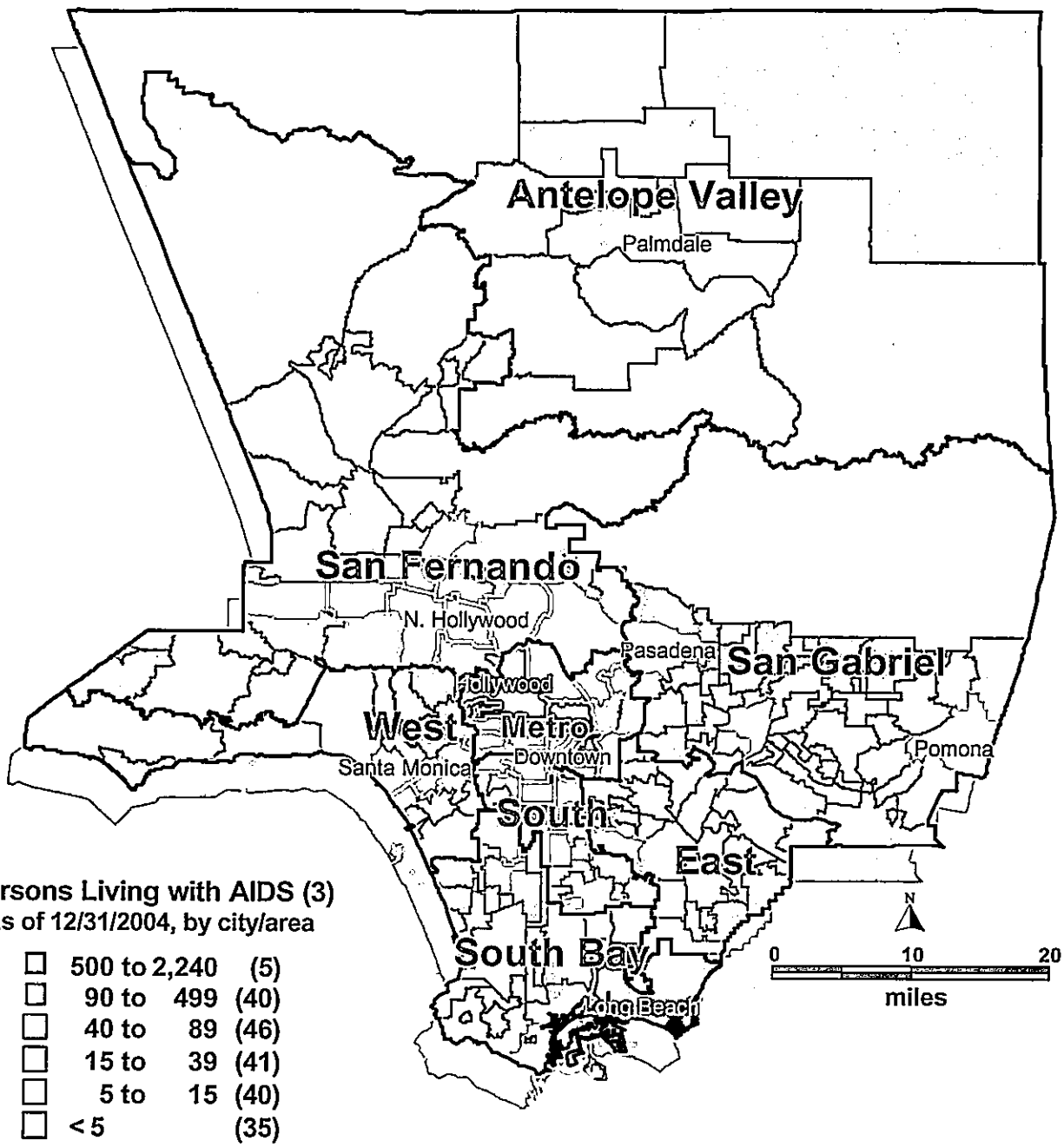
Total number of live births in Los Angeles County, 2002 = 151,167

Note: Low birthweight is defined as weight less than 2,500 grams at birth

Source: California Department of Health Services,
Center for Health Statistics, Vital Statistics, 2002

n = total number of zip codes in range

FIGURE 11. PERSONS REPORTED LIVING WITH AIDS AS OF 12/31/2004(1) BY CITY/AREA(2) AND SERVICE PLANNING AREA (SPA) IN LOS ANGELES COUNTY (N=20,316)



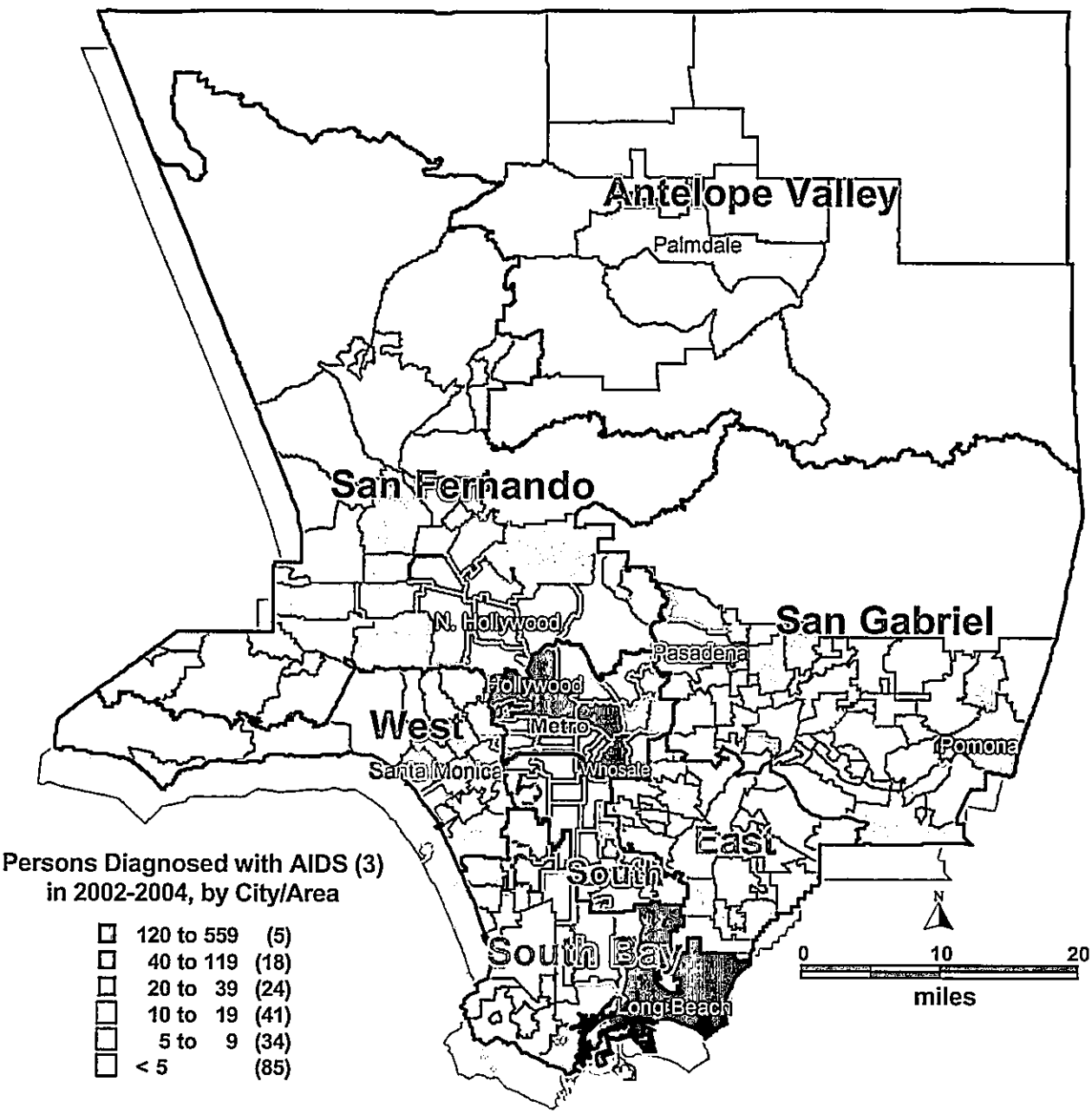
Persons Living with AIDS (3)
as of 12/31/2004, by city/area

☐	500 to 2,240	(5)
☐	90 to 499	(40)
☐	40 to 89	(46)
☐	15 to 39	(41)
☐	5 to 15	(40)
☐	< 5	(35)

1. Data are provisional due to reporting delay for newly diagnosed cases and death reports.
2. City of Los Angeles is broken down into "areas' or geographical units. Residence is based on address at time of AIDS diagnosis.
3. Does not include 1,162 persons (6%) who had no specific address at time of the AIDS diagnosis.

HIV Epidemiology Program
DHS. LAC 01/05

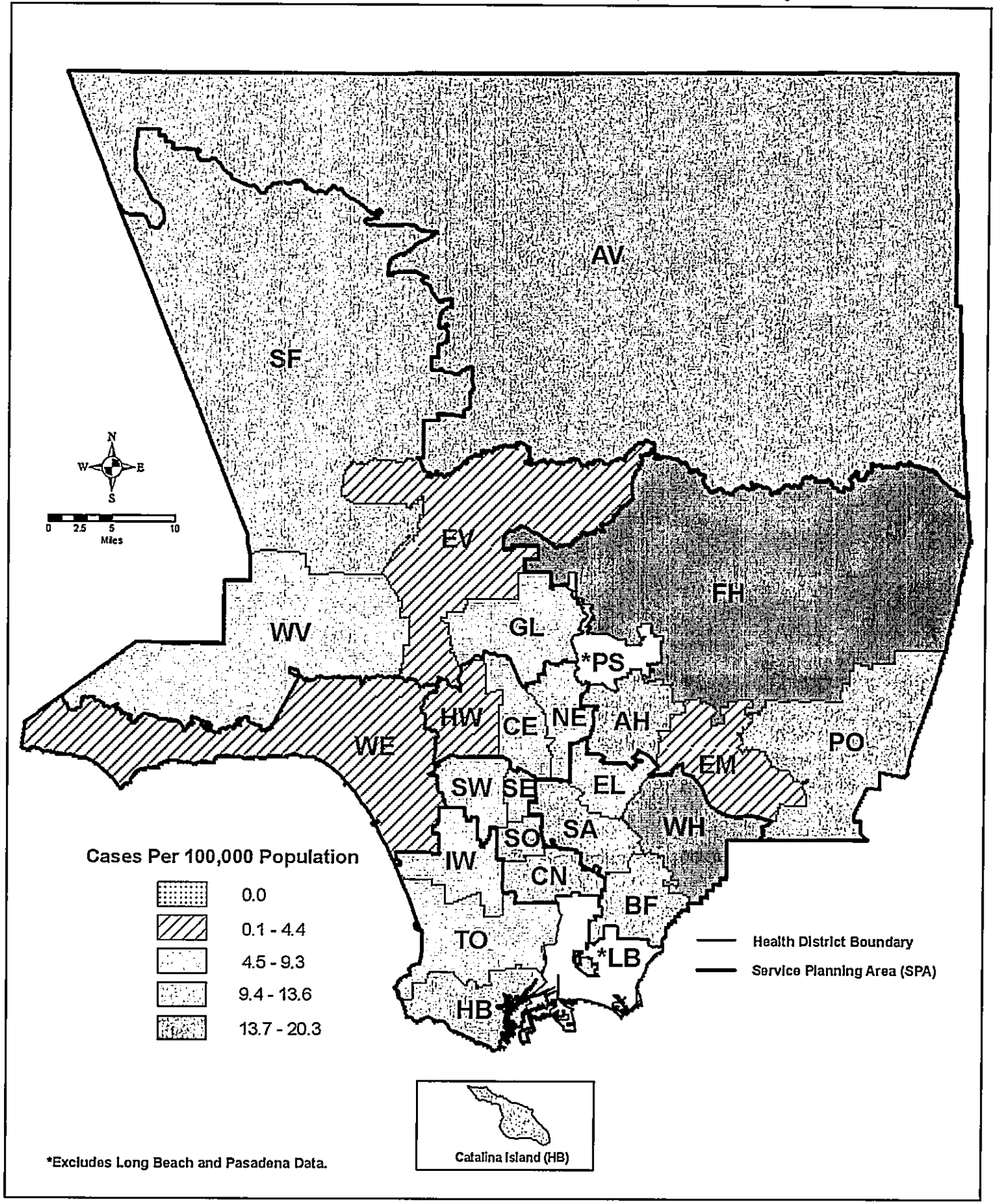
FIGURE 10. PERSONS DIAGNOSED WITH AIDS IN 2002-2004(1) BY CITY/AREA(2) AND SERVICE PLANNING AREA (SPA) IN LOS ANGELES COUNTY (N=4,420)



1. Data are provisional due to reporting delay.
2. City of Los Angeles is broken down into "areas' or geographical units. Residence is based on address at the time of AIDS diagnosis.
3. Does not include 323 persons (7%) who had no specific address at the time of AIDS diagnosis.

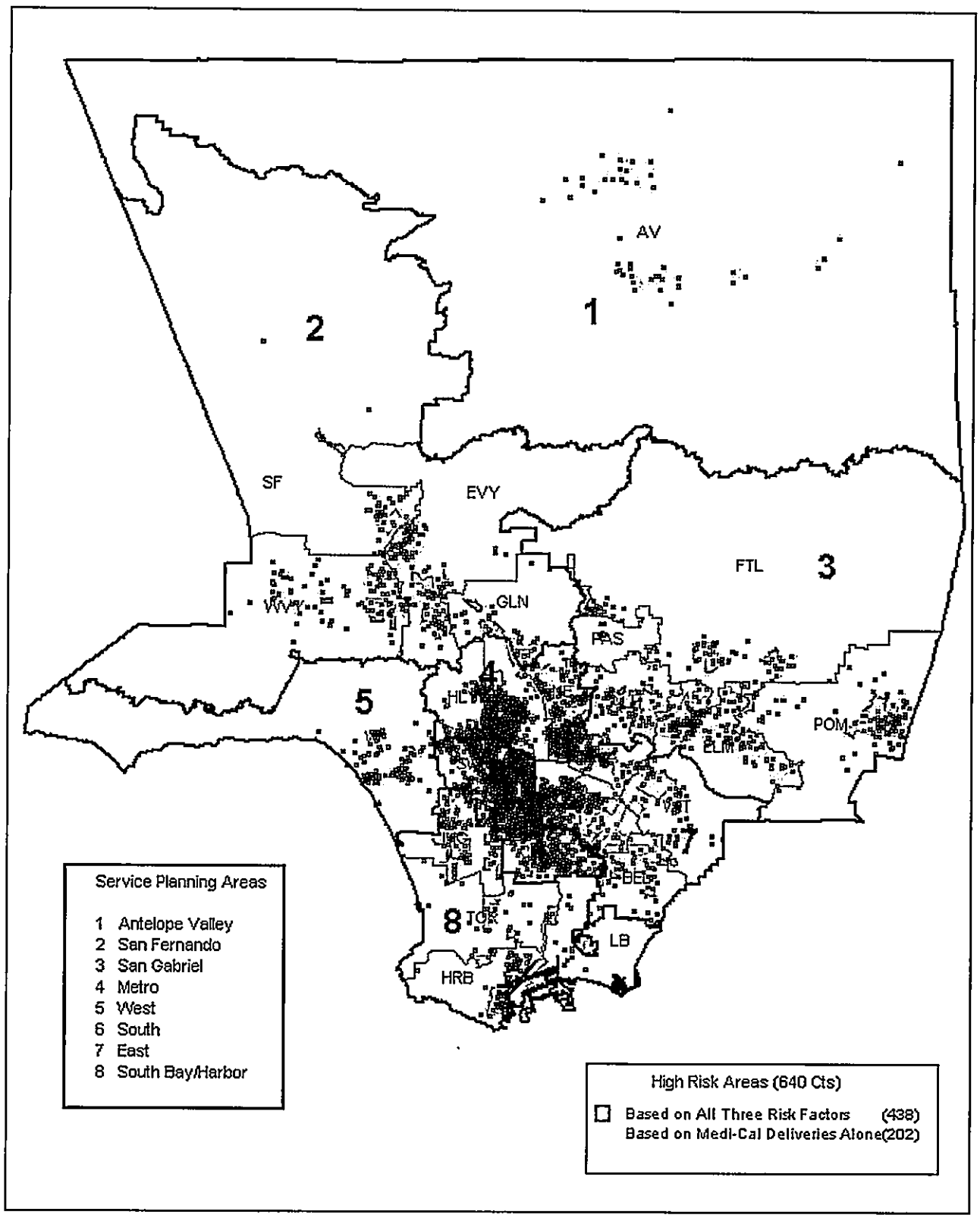
HIV Epidemiology Program
DHS. LAC 07/05

Map 9. Meningitis, Viral
Rates by Health District, Los Angeles County, 2004*



*Excludes Long Beach and Pasadena Data.

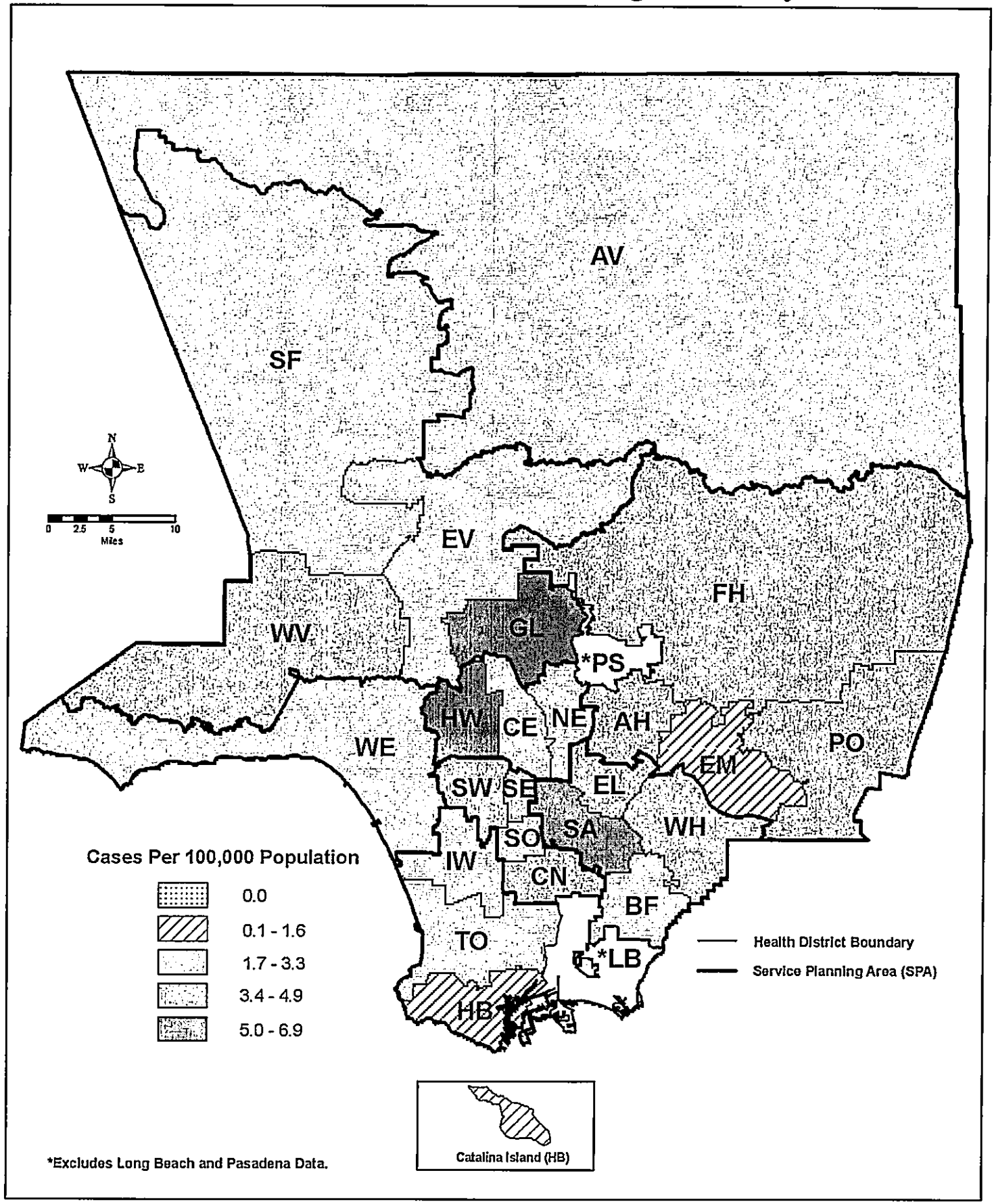
Distribution of Reported Lead Poisoing Cases against High Risk Areas in Los Angeles County



Reported, geocodable cases=5,039; 65% in the 640 CTs.

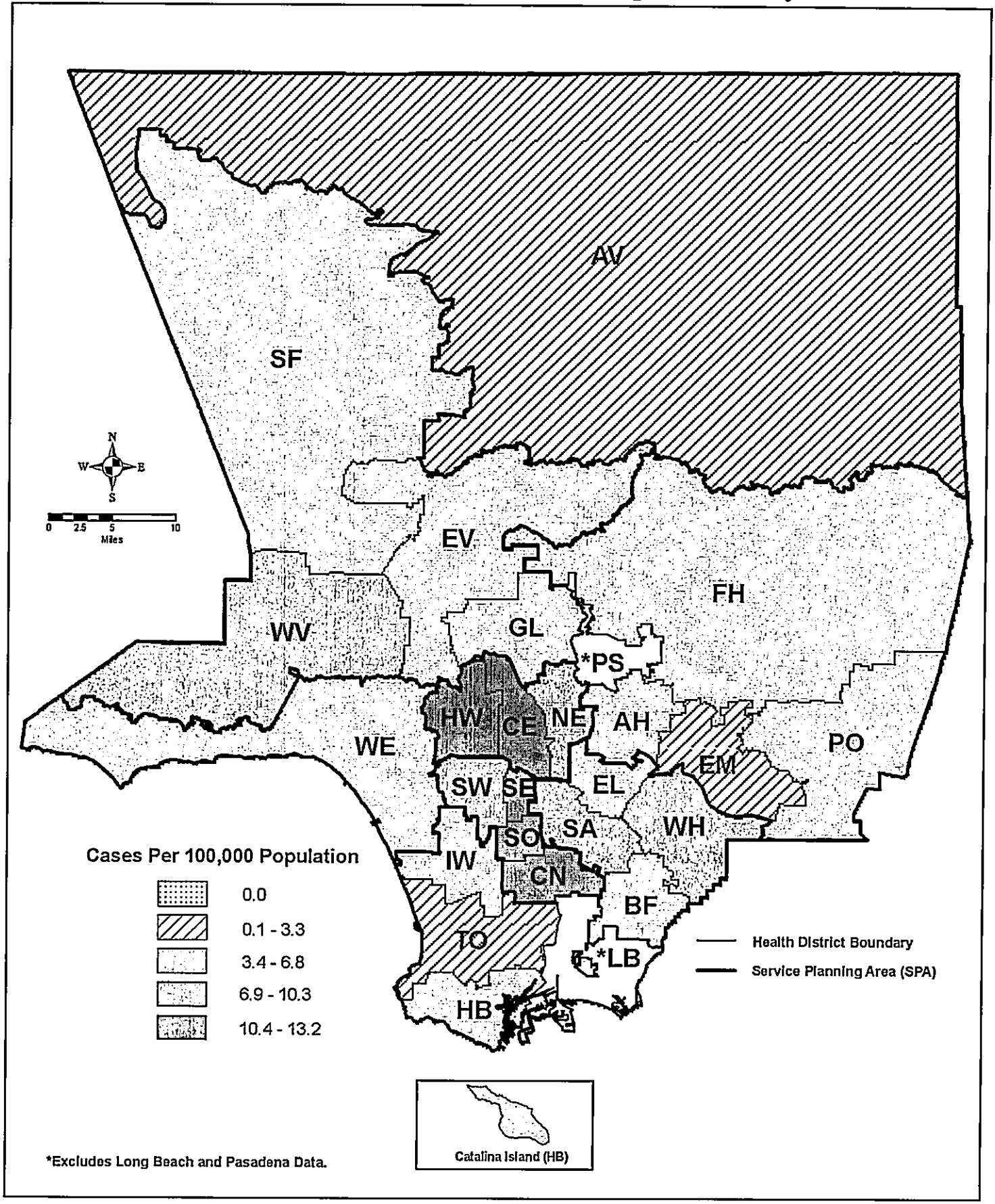
LAC-DHS Childhood Lead Poisoning Prevention Program - 2/24/04

Map 7. Hepatitis A
Rates by Health District, Los Angeles County, 2004*



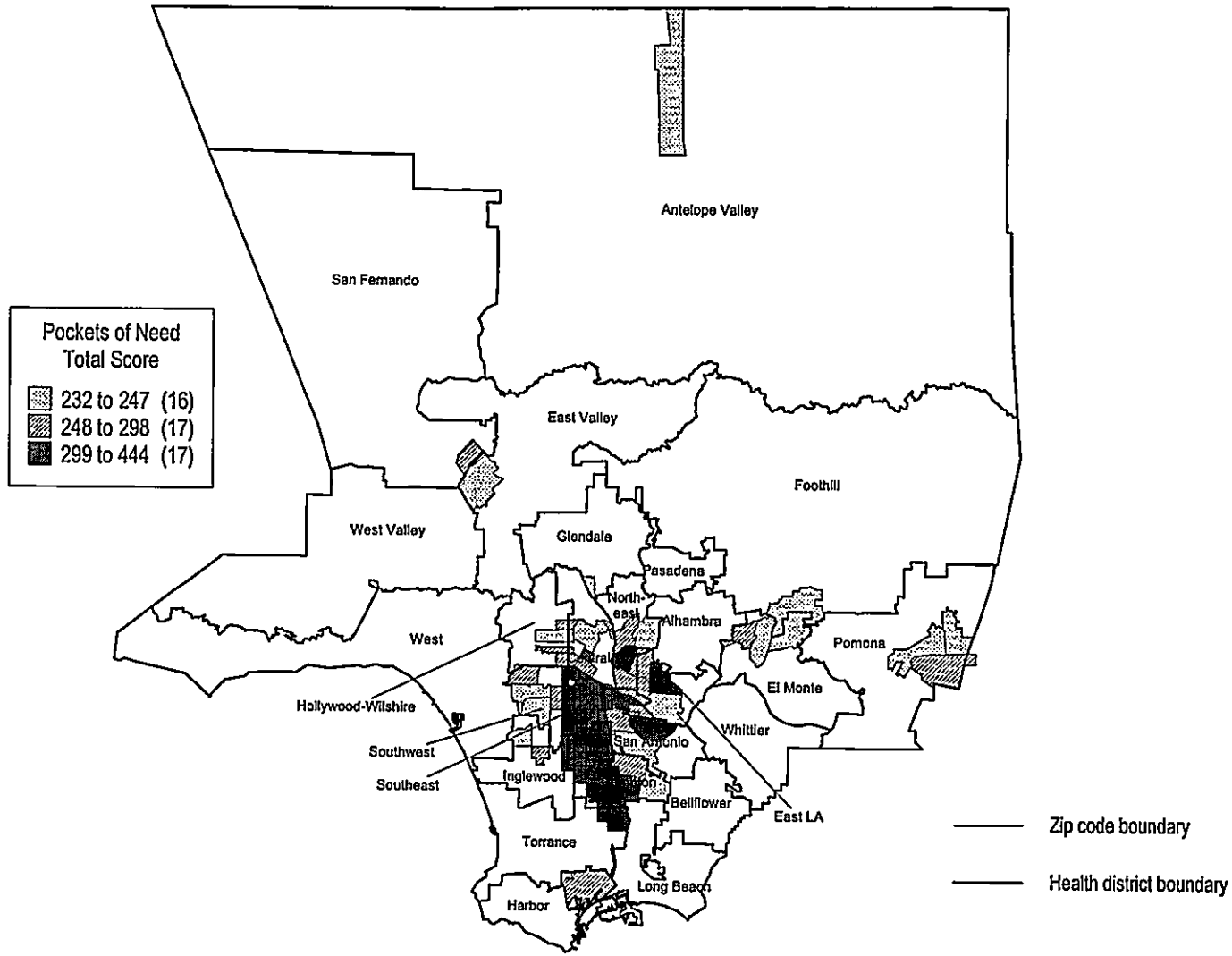
*Excludes Long Beach and Pasadena Data.

Map 12. Shigellosis
Rates by Health District, Los Angeles County, 2004*



*Excludes Long Beach and Pasadena Data.

Figure 1. Fifty pockets of need selected from zip codes above the medians for the proportion of children less than six years of age and 1989-1991 cumulative measles incidence rate, Los Angeles County.



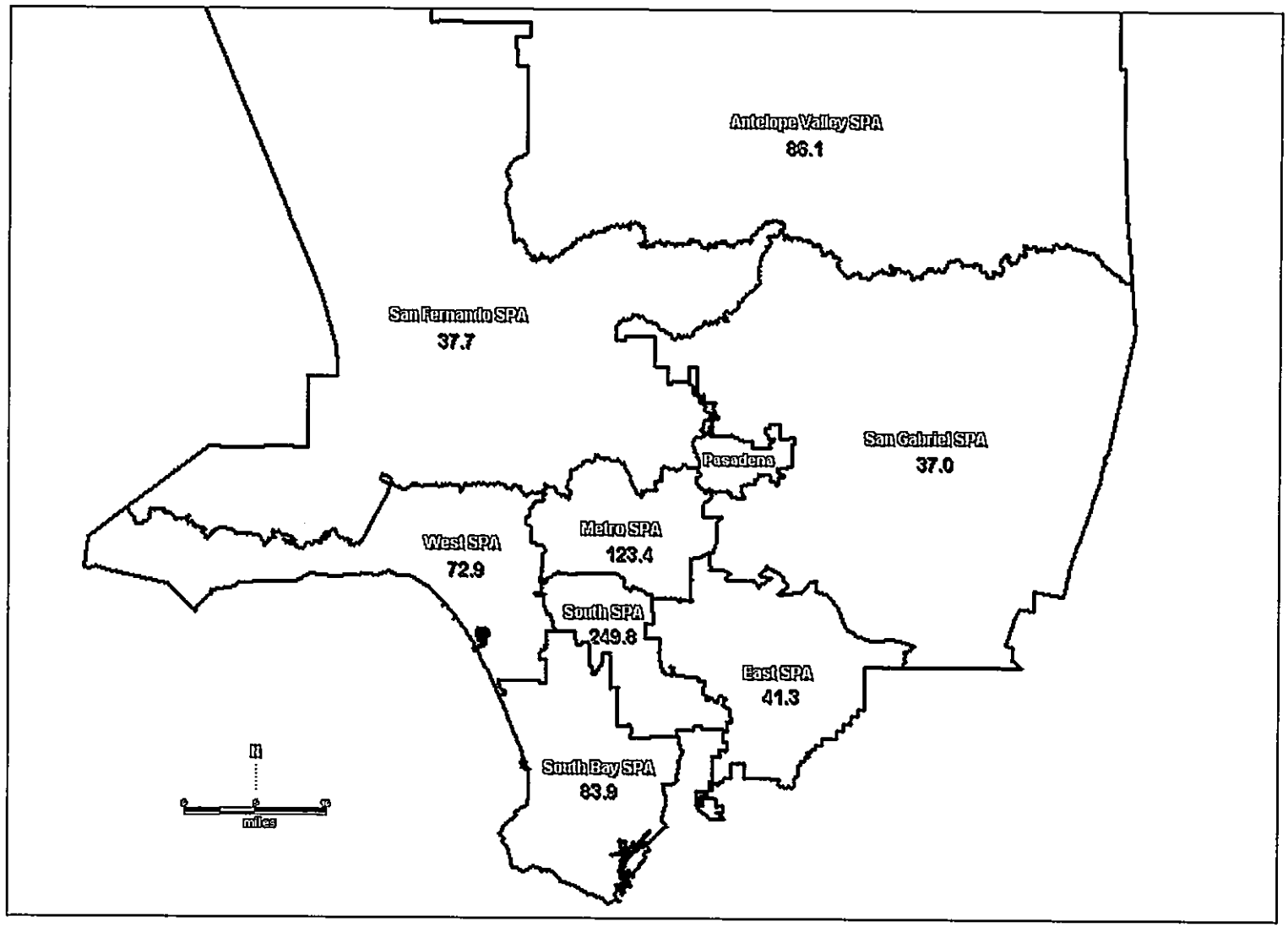


Figure 4. 2003 Reported Gonorrhea Rates per 100,000 Population by Service Planning Area (SPA), Los Angeles County.

Excludes cases from Pasadena (SPA 3) and Long Beach (SPA 8).

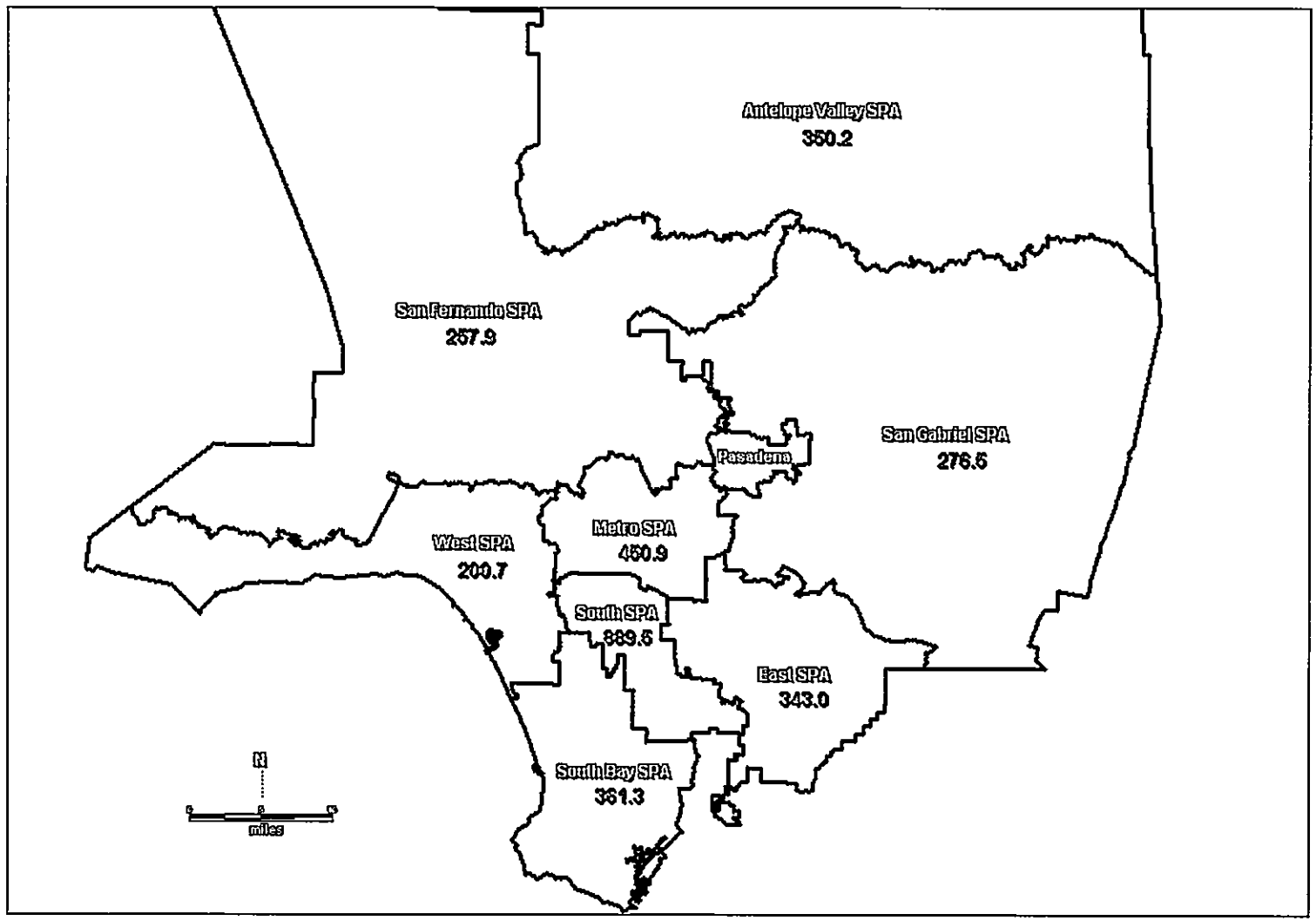


Figure 2. 2003 Reported Chlamydia Rates per 100,000 Population by Service Planning Area (SPA), Los Angeles County.

Excludes cases from Pasadena (SPA 3) and Long Beach (SPA 8).